STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Washington

NURSING FACILITIES AND SWING BED HOSPITALS
Effective October 1, 1998

Section I. Introduction:

The following State Plan Amendment (SPA), Attachment 4.19-D, Part I, describes the overall payment rate methodology for nursing facility services provided to Medicaid recipients by (1) privately-operated nursing facilities, both non-profit and for-profit, and (2) by nursing facilities serving veterans of military service operated by the State of Washington Department of Veterans Affairs. Both privately-operated and veterans' nursing facilities share the same methodology.

The SPA is submitted by the single state agency for Medicaid, the State of Washington, Department of Social and Health Services ("department" below). This amendment is necessary to describe the payment methodology prescribed by the 1998 state legislature commencing October 1, 1998. (See Chapter 74.46 RCW as amended by Engrossed 2nd Substitute House Bill 2935, - Washington Laws of 1998, Chapter 322).

Excluded here is the payment rate methodology for nursing facilities operated by the department's Division of Developmental Disabilities, which is described in Attachment 4.19-D, Part II.

Chapter 388-96 of the Washington Administrative Code (WAC) and chapter 74.46 of the Revised Code of Washington (RCW), both amended as of October 1, 1998, are incorporated in Attachment 4.19-D, Part I by reference as if fully set forth. Washington Laws of 1998, Chapter 322, sections
"P & I" 29 and 30 are also incorporated in Attachment 4.19-D, Part I as if fully set forth. Copies of these provisions are enclosed as Appendix A, Appendix B and Appendix C, respectively, to TN 98-11.

The methods and standards used to set payment rates are specified in this SPA in a comprehensive manner only. For a more detailed account of the nursing facility payment methodology for rate setting effective October 1, 1998, consult chapters 388-96 WAC and 74.46 RCW, as amended as of this date. In case of conflict between the detailed provisions of these chapters and the comprehensive narrative description set forth in Attachment 4.19-D, Part I, the regulatory and statutory provisions shall prevail.

The methods and standards employed by the department comply with 42 CFR Part 447, Subpart C.

Nursing facility per resident day rates will continue to be facility-specific and some component rates will be subject to a settlement process of comparing payments to facility expenditures, to help ensure vital services are provided to residents of facilities. The total rate resulting from the settlement process represents final compensation for the settlement period, normally corresponding to a calendar year.

Section II. General Provisions:

The changes in the present SPA commence a "case mix" payment system linking payment to the acuity level and service needs of a nursing facility's resident population.

The prospective rate assigned to each nursing facility and adjusted periodically, will have six components: direct care, therapy care, support services, operations, property, and return on investment. The return on investment component rate is further composed of two elements: a financing allowance and a variable return allowance.

Prior to rate setting, nursing facilities' costs and other reported data shall be examined to ensure accuracy and allowability. The rates established under the new methodologies cannot exceed, in "P & I" the aggregate, the statewide average payment rate maximum or limit specified in the biennial appropriations act. At this time, for state fiscal year 1999, the amount is $117.36 per resident day. Should the statewide average payment rate exceed or be likely to exceed the specified limit, then all rates will be subject to a proportionate, prospective reduction to ensure the aggregate average is not exceeded.

The direct care component will incorporate case mix principles. This component is projected to be about fifty-six percent of each facility's new total rate.

Facility-specific, adjusted cost data, used to set component rates for direct care, therapy care, "P & I" support services and operations shall be from calendar year 1996 cost reports for the October "P & I" 1, 1998 through June 30, 2001 combined rate period; and shall be from calendar year 1999 cost reports for the July 1, 2001 through June 30, 2004 combined rate period.

These four components shall be subject to annual adjustment for economic trends and conditions by a factor specified in the biennial appropriations act.

In arraying costs for setting these four component rates, the department will continue to make a distinction between the costs of nursing facilities located in a metropolitan statistical area and those not in such an area (MSA and non-MSA facilities).

Section III. Allowable Costs:

Allowable costs for rate setting, audit and settlement are documented costs, not expressly declared unallowable or otherwise limited under chapters 74.46 RCW or 388-96 WAC, that are necessary and ordinary and related to the care of nursing facility residents. To be ordinary nursing facility expenses, costs must be of the nature and magnitude that prudent and cost-conscious management would pay. Pursuant to statue and regulation, costs in excess of limits or in violation of any rate setting or payment principles contained in chapters 74.46 RCW or 388-96 WAC are deemed expressly unallowable.

These limits include the MSA and non-MSA peer group median costs, plus applicable percentages allowed over the MSA and non-MSA median costs in the various component rates described below. These limits, including the percentages allowed above the median costs, are generally referred to as median cost limits or MCLs.

Allowable cost limits and principles of rate setting and payment include, in the broad sense, not only MCLs and other limitations of chapters 74.46 RCW and 388-96 WAC, but those contained in all applicable state and federal laws and regulations, in effect on October 1, 1998, or adopted afterward, as may be interpreted by courts of competent jurisdiction.

The Washington Medicaid payment system for nursing facility services does not guarantee that all costs relating to the care of a nursing facility's Medicaid residents and allowable under the payment system rules will be fully covered in any payment period. The primary goal of the system is to pay for nursing care in accordance with state and federal laws, not to reimburse the costs of a provider.

Section IV. Adjustments for Economic Trends and Conditions:

Direct care, therapy care, support services and operations component rates shall be adjusted annually, October 1, 1998 and each July 1, thereafter, for economic trends and conditions by a factor or factors defined in the state biennial appropriations act.

For October 1, 1998, the factor shall be 5.18% for all four component rates applied to 1996 adjusted costs.

Calculation of all rate components requires the use of resident days at a facility. A facility's resident days will be taken from the applicable cost report, and the department will use the greater of days based on actual occupancy or days based on imputed occupancy at eighty-five percent.

Section V. Direct Care Component Rate:

This component corresponds to one resident day of nursing care, including supplies, except therapy care and related supplies. Direct care costs from the appropriate cost report (1996 or 1999) for each facility will be divided by resident days from the same report period, increased, if necessary, to an imputed occupancy of eighty-five percent.

Therapy costs will be eliminated from direct care costs because they will be used to determine the therapy care component. Adjustments for economic trends and conditions will be made to the remaining costs to derive allowable direct care costs.

Using data from facility-completed, mandatory assessments of individual residents, and a software program that groups residents by care needs, the department shall determine for each facility both a facility average case mix index (for all residents) and a Medicaid average case mix index (for Medicaid residents only). A case mix index is a number representing the intensity of need for services by a resident population or group within a population.

Each facility's allowable direct care cost per resident day will be divided by the facility average case mix index to derive the facility's allowable direct care cost per case mix unit.

Facilities' allowable direct care costs per case mix unit shall be arrayed separately for MSA and non-MSA facilities. The median cost per case mix unit for each peer group will be determined.

For October 1, 1998 through June 30, 2000 rate setting, the facility's direct care cost per case mix unit will be adjusted, if necessary, to bring it up to the floor of eighty-five percent of the facility's MSA or non-MSA peer group median, or down to the ceiling of one hundred fifteen percent of the peer group median.

For July 1, 2000 through June 30, 2002 rate setting, the floor is

set at ninety percent and the ceiling is set at one hundred ten percent of the applicable peer group median.

For July 1, 2002 to June 30, 2004 rate setting, the floor is set at ninety-five percent and the ceiling is set at one hundred five percent of the applicable peer group median.

For July 1, 2004 forward, a price will be set at the peer group median, with no floor or ceiling adjustment.

For all rate periods, a facility's direct care component rate shall be equal to its allowable direct care cost per case mix unit from the applicable cost report period, multiplied by its Medicaid average case mix index from the specified quarter.

Direct care rates shall be updated on the first day of each calendar quarter to reflect changes in a facility's case mix over time. The resident assessment data used for each update shall be from the quarter commencing six months, and ending three months, prior to the effective date of each quarterly adjustment.

For the period October 1, 1998 to June 30, 2000, no facility shall receive a rate less than its June 30, 1998 nursing services component rate, less therapy costs plus exceptional care offsets as reported on the cost report. For the period July 1, 2000 to June 30, 2002, no facility shall receive a direct care component rate less than its direct care component rate in effect on June 30, 2000.

Section VI. Therapy Care Component rate:

"P & I" This payment corresponds to one-on-one care from qualified therapists delivered to a Medicaid resident, on average, during one day and to therapy consultation delivered to a resident, on average, during one day. Allowable one-on-one therapy costs will be calculated to determine the allowable cost per Medicaid resident day, as opposed to per resident day for all residents, for other "P & I" component rates, and for therapy consulting costs used to help determine the therapy care component rate.

"P & I" To set the therapy care component rate, the department will take, from 1996 or 1999 cost reports, as applicable, direct one-on-one therapy charges for all residents by payer, including costs of supplies, total units or modules of therapy care for all residents from the report period by type of therapy provided, and therapy consulting expenses for all residents.

The department will determine the total cost for each type of therapy care (e.g., speech, physical, occupational) at each nursing facility, and divide by the facility's total units of therapy for each therapy type, to derive the per unit cost for all residents.

A unit is defined as fifteen minutes of one-on-one therapy. The department will "P & I" rank from lowest to highest per unit one-on-one therapy costs and per resident day therapy consulting expenses for MSA and non-MSA facilities, separately for each "P & I" type of therapy, and determine the median cost per unit for one-on-one therapy and median cost per resident day for therapy consulting for each peer group and "P & I" therapy type. The department will then establish a limit at one hundred and ten percent of the median cost per unit for one-on-one therapy and one hundred and ten percent of the median cost per resident day for therapy consulting, for each peer group and therapy type.

"P & I" A facility's maximum allowable cost per unit for one-on-one therapy for each therapy type, and maximum allowable cost per resident day for therapy consulting for each therapy type, will be the lower of the facility's actual per unit cost or per resident day cost or the limit per unit or per resident day for its peer group.

A facility's allowable cost per unit for each therapy type will then be multiplied by the units supplied in each category. This result is then multiplied by the Medicaid percentage of charges for each category, and divided by adjusted Medicaid resident days from the report period, to derive the Medicaid resident day allowable expense for each therapy type.

"P & I" The allowable Medicaid day one-on-one and allowable resident day consulting cost for each therapy type will be multiplied by total adjusted resident days to calculate the facility's total allowable one-on-one and consulting therapy expenses. These two totals for each type will be combined to derive each facility's total allowable costs for each therapy type.

The total allowable cost for each therapy type for each nursing facility will be combined and divided by total adjusted resident days, or days imputed at eighty-five percent occupancy, whichever is greater, to derive the therapy care component rate.

Section VII. Support Services Component Rate:

This component corresponds to one resident day of food, food preparation, dietary, housekeeping and laundry services.

To set the component rate, the department will take, from 1996 or 1999 cost reports, as applicable, allowable support services costs, and divide by adjusted resident days from the same cost report.

The department will array allowable costs separately for MSA and non-MSA facilities, and determine the median cost for each group. Costs used to set a facility's support services rate will be the lower of its actual allowable costs or the median of its peer group plus ten percent.

Section VIII. Operations Component Rate:

This component corresponds to one resident day of operations, and includes administrative services, management, utilities, accounting, minor building maintenance, etc.

To set the component rate, the department will take, from 1996 or 1999 cost reports, as applicable, allowable operations costs, and divide by adjusted resident days from the same cost report.

The department will array allowable operations costs separately for MSA and non-MSA facilities, and determine the median cost for each group. Costs used to set a facility's operations component rate will be the lower of its actual allowable costs or the median of its peer group.

Section IX. Property Component Rate:

This component rate corresponds to an allowance for depreciation of real property improvements, equipment and personal property associated with the provision of resident care at a nursing facility.

Effective October 1, 1998 this component will be rebased on 1997 adjusted, allowable depreciation for each facility divided by its 1997 resident days. Resident days shall be determined by actual 1997 occupancy or imputed occupancy of eighty-five percent, whichever is greater.

This component will be redetermined by the same procedure annually, effective July 1, using depreciation from the immediately preceding report year (1998 for July 1, 1999; 1999 for July 1, 2000, etc.) The property component will be adjusted as needed to reflect the cost of capitalized additions and replacements.

For assets that were acquired after January 1, 1980, the depreciation base of the assets will not exceed the net book value which did exist or would have existed had the previous contract continued, unless the assets were acquired after January 1, 1980 for the first time since that date and before July 18, 1984.

The depreciation base that will be used for first-time sales after January 1, 1980, but occurring pursuant to a written and enforceable purchase and sales agreement in existence prior to July 18, 1984, and documented and submitted to the department prior to

January 1, 1988, will be that of the first owner subsequent to January 1, 1980.

Subsequent sales during the period defined above, and any subsequent sale of and any asset, whether depreciable or not depreciable, on or after July 18, 1984, are ignored for payment purposes.

Section X. Return on Investment:

This component will continue to have two parts: a financing allowance and a variable return allowance.

Financing Allowance --

The financing allowance subcomponent rate is paid in lieu of payment determined by actual lease and interest expense, except for the cost of leasing office equipment, which is factored into the operations component rate. The financing allowance represents payment based on ten percent of a facility's adjusted net invested funds from the preceding calendar year report period.

For payment purposes, a facility's net invested funds consists of the recognizable value of tangible fixed assets and the allowable cost of land employed by the contractor to provide nursing facility services, plus an allowance for working capital. Valuation of allowable land will be subject to the same purchase date limitations affecting depreciable assets described in Section X.

A facility's financing allowance will be reset October 1, 1998, and annually each July 1 thereafter based on cost report data for the prior calendar year (1997 for October 1, 1998; 1998 for July 1, 1999, etc.) It will be computed by multiplying a facility's allowable net invested funds from its most recent cost report by ten percent, and dividing by resident days from the same cost report. Resident days used shall be actual or imputed at eighty-five percent occupancy, whichever is greater.

Net invested funds is essentially net book value of tangible fixed assets used in providing services at the facility, plus an allowance for working capital. In calculating net invested funds, facilities will continue to be subject to the cost basis of the last owner of record prior to July 18, 1984, for assets existing prior to that date.

Variable Return Allowance --

This return on investment subcomponent rate is an efficiency incentive to reduce costs. To compute the variable return, the department will rank all facilities, without the use of MSA or non-MSA peer groups, according to each facility's 1996 combined allowable nursing services, food, administrative and operational costs.

The department will assign a percentage to each facility as follows: one percent, if the facility is in the highest quartile; two percent, if the facility is in the next highest quartile; three percent, if the facility is in the next lowest quartile; and four percent, if the facility is in the lowest quartile.

This percentage will be multiplied by the facility's combined per resident day component rates in direct care, therapy care, support services and operations as of October 1, 1998, to derive the variable return.

Section XI. Settlement:

In a process called "settlement", payments to a facility corresponding to direct care, therapy care, and support services (food, food preparation, dietary, laundry and housekeeping) will be compared to its expenditures in these categories each report period. The facility must return to the department all unspent payments exceeding one percent of the amount paid to the facility in each category, but may keep unspent payments not exceeding one percent.

However, facilities which provide substandard care, or which are not in substantial compliance with care standards during the settlement period, will not be allowed to retain any unspent payments in these three areas. Also, no overpayments may be retained in any cost area into which excess payments in another area or areas have been shifted under applicable rules, to cover a deficit.

In contrast, payments for operations, property and return on investment shall not be subject to recovery under the settlement process if not spent. However, the return on investment (ROI) financing allowance subcomponent rate is subject to adjustment up or down to reflect net invested funds, as determined by audit, and no nursing facility may retain ROI payments representing financing allowance payments to the extent reported net invested funds cannot

be substantiated at audit.

In calculating settlements, no shifting of costs or rate funds between cost areas will be allowed; except that, any savings in support services (rate exceeds cost) may be shifted to cover a deficit in direct care or therapy care up to twenty percent of the support services component rate.

A facility's rate components and total rate determined by the settlement process shall represent final and maximum payment for services rendered during the settlement period.

Section XII. Adjustments to Prospective Rates:

The department may grant prospective rate increases to fund new requirements imposed by the federal government or by the department, if the department determines a rate increase is needed in order to implement the new requirement.

Rates may be revised prospectively to fund capitalized facility additions and replacements meeting applicable conditions, such as certificate of need approval, if required.

Rates may be adjusted prospectively and retrospectively to correct errors or omissions on the part of the contractor or the department, or to implement the final result of a provider appeal, or to fund the costs of placing a nursing home in receivership and aid the receiver in correcting deficiencies.

Section XIII. Rates for Swing Bed Hospitals:

Rates for swing bed hospitals providing nursing facility care continue to be set for each state fiscal year (July 1 through June 30) at the approximate, weighted, statewide average paid to nursing facility providers during the preceding July 1 through June 30 state fiscal year.

The average Medicaid nursing facility rate is computed by first multiplying each provider's approximate rate on July 1 of the preceding state fiscal year by the provider's approximate number of resident days for the month of July during the preceding year. Total payments for all nursing facilities for July of the preceding year are then added and divided by total resident days for the same month to derive a weighted average for all Medicaid nursing facilities.